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Valuation of Compensation for Healthcare Services: Physician On-Call Services (Part Three of a Four-Part Series)

As discussed in Part One of this series, *healthcare services* may be divided into two general categories, i.e., *clinical related* and *nonclinical related*, with these categories further defined by the specific *tasks*, *duties*, *responsibilities*, and *accountabilities* (TDRAs) involved in each.[1] Due to the many permutations and combinations of TDRAs that may be present in various healthcare service roles, careful analysis is warranted to ensure that the subject services (i.e., those services under consideration in the valuation engagement) are classified into an appropriate category for benchmarking and other valuation related purposes.[2]

One subcategory of healthcare services that mandates careful consideration by the valuation analyst is *physician on-call services*, which denotes the requirement that a physician be responsible for providing professional clinical services to patients who may need care during a time other than typical physician practice office hours (e.g., on evenings, weekends, and holidays) at various sites of services, including hospital emergency departments, trauma centers, and birthing centers.[3] This third installment in the four-part *Health Capital Topics* series on the classification and valuation of physician compensation for healthcare services will focus on *physician on-call services* in the healthcare industry.

Similar to the valuation of compensation arrangements for other *physician clinical services* (discussed in Part One of this series), the *economic value* analysis for determining *Fair Market Value* (FMV) for *physician on-call services* should be focused on the *economic benefits* reasonably expected to be derived from the *use* or *utility* of the services *in the future*, bounded by the *cost* of an *equally desirable substitute*, or one of *equal utility*, for *each of the elements* of *economic benefit* (or *utility*) to be derived from the *right to control* the services to be performed.[4]

As set forth in two Advisory Opinions by the Office of the Inspector General of Health and Human Services (May 2009 and March 2013), compensation for *physician on-call services* should be based on *services actually rendered.*[5] Further, reliance on the physician's "*lost opportunity cost*" as the sole basis for determining *physician on-call services* compensation may not be considered an efficacious methodology for determining whether a compensation arrangement meets the regulatory thresholds of FMV and *commercial reasonableness*.[6]

In developing the valuation analysis related to *physician on-call services*, the valuation analyst will need to obtain the requisite documents related to the proposed compensation arrangement(s), including:[7]

(1) *The proposed agreement(s)* for on-call services (including a detailed description of all TDRAs related to the services to be performed);
(2) *The time requirements*, e.g., the *number of hours* or *number of shifts* per week anticipated under the proposed arrangement;
(3) *The number of times* the current (specialty specific) on-call physician was (a) *paged* and (b) *required to be present* at the hospital for the last two years;
(4) *The curriculum vitae for each physician* performing the on-call services;
(5) *Documentation* as to the *board certification*, *qualifications*, and *tenure* of those providers performing *on-call services* under similar agreements;
(6) *The medical staff bylaws* and roster;
(7) *Agreements for other similar positions* at the employer entity, including the *scope of services* to be performed under each of those agreements;
(8) *Documentation as to the size of the employer*, *number of patients*, *acuity levels of patients*, and *specific needs* related to the organization; and,
(9) *Documentation of historical clinical productivity*, measured in *work Relative Value Units* (wRVUs), *gross charges*, *net revenue*, or *count by Current Procedural Terminology (*CPT) *code* for an applicable time period (typically the last two years or more, depending on the facts and circumstances) to establish a relevant trend for forecasting purposes.

The valuation analyst utilizes this data to *identify* and *classify* the types and number of tasks and duties, along with the level of responsibility and accountability held by the provider, associated with the subject arrangement for *physician on-call services*.

Similar to *clinical-related services*, once the TDRAs for the *physician on-call services* to be provided are established, the proposed compensation arrangement

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should be compared to applicable, external benchmarking survey sources reflecting similar TDRAs in order to assess whether the compensation arrangement meets the regulatory thresholds of FMV and *commercial reasonableness*. This "*benchmarking analysis*" for *physician on-call services* should include the following steps to ensure that the most relevant external benchmarking data is used for comparison purposes:[8]

(1) Determine the specific characteristics of the arrangement, including:
   (a) Specialty/subspecialty of the provider;
   (b) Applicable job training and education level of the provider, relevant to the position;
   (c) Number of years of experience and reputation of the provider;
   (d) Site of service (e.g., hospital emergency departments, trauma centers, and birthing centers); and,
   (e) Geographic location where the subject services are to be provided;

(2) Establish the *homogenous units of economic contribution* to be used as the *metric(s) of comparability*. Typically, compensation arrangements for *physician on-call services* are based on time metrics (e.g., annual, monthly, hourly); and,

(3) Develop the range of applicable, normative benchmark industry data, which should include *measures within the range* (e.g., 10th percentile, 25th percentile, 75th percentile, 90th percentile), as well as *measures of central tendency* (e.g., mean, median) and *measures of dispersion* (e.g., standard deviation). The *range of normative benchmark industry data* is typically compiled by taking a weighted average of the selected benchmark data from external sources that report the specified *metric(s) of comparability*. The percentage of consideration assigned to each data source, used to compile the *range of normative benchmark industry data*, should include contemplation of the following statistical and descriptive survey characteristics: [9]
   (a) *Size* of the data population sample included in the external benchmark survey;[10]
   (b) *Dispersion* of the data – it should be noted that a useful metric for comparing the relative dispersion between data sets for the purposes of determining an applicable weight of consideration in calculating a range of applicable, normative benchmark industry data is the *coefficient of variation* (for information regarding this statistical technique, please reference the September 2016 *Health Capital Topics* article entitled *"Statistical Methods – Co-Efficient of Variation"*);
   (c) *Geographic proximity* in relation to the area in which the subject services will be provided; and,
   (d) *Other areas of comparability* between the external benchmark survey source and the subject services (e.g., whether the external benchmark survey source includes elements of compensation not present in the subject *physician on-call services*, the date the external benchmark survey was compiled).

It should be noted that some compensation arrangements for *physician on-call services* allow the physician to be compensated for the services provided, as well as to *bill and collect for* the *professional clinical services provided* while "*on-call*."[11] Other compensation arrangements for *physician on-call services* compensate the physician *only* for the *on-call services component*, while the *entity location bills and collects for the professional services.*[12] This may be particularly true of *hospital-employed physicians* (e.g., *radiologists*, *anesthesiologists*, *pathologists*, *emergency department providers*, and *hospitalists*) who do not receive compensation based on a productivity formula.[13] Because some benchmarking surveys report compensation levels based on the ability of the physician *to bill and collect* for his or her professional services while performing *on-call services*, adjustments to the benchmark data may be necessary when comparing on-call arrangements where the physician is not entitled to collect for the professional services provided.[14]

The final article in this four-part series on the valuation of compensation for healthcare services will discuss the valuation of *medical director compensation* arrangements in the healthcare industry.

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1 "Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Hoboken, NJ: John Wiley and Sons, 2014, p. 863.
2 *Ibid*, p. 867.
3 *Ibid*.
4 *Ibid*, p. 917.
5 "Re: OIG Advisory Opinion No. 09-05" By Lewis Morris to [Name Redacted], May 14, 2009, https://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-05.pdf (Accessed 10/4/2012), p. 7;; "Re: OIG Advisory Opinion No. 12-15" By Gregory E. Demske to [Name Redacted], March 8, 2013, https://oig.hhs.gov/fraud/docs/advisoryopinions/2012/AdvOpn12-15-mod.pdf (Accessed 11/21/16).
6 "Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Hoboken, NJ: John Wiley and Sons, 2014, p. 917.
7 Cimasi, 2014, p. 917-918.
8 *Ibid*, p. 918-919.
9 *Ibid*, p. 919.
10 *Ibid*.
11 *Ibid*.
12 *Ibid*.
13 *Ibid*.
14 *Ibid*.

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